Chapter 14: **Developments in treatment for drug misuse offending**

Introduction

> *"Occasional drug use is not the principal cause of Britain's drug problems. The bulk of drug-related harm (death, illness, crime and other social problems) occurs among the relatively small number of people that become dependent on Class A drugs, notably heroin and cocaine."* (Reuter & Stevens, 2007, p.7).

The drug treatment of offenders is a contentious issue steeped in political debate and clouded in media commentary about the rights of those who are estimated to commit up to half of the United Kingdom's acquisitive crimes (HMG, 2008). The aim of this Chapter is to provide the reader with an overview of developments in the treatment for drug misuse offending. Initially, however, a general review of drugs and crime will be conducted. This will be followed by a background review of the development of treatment services in the United Kingdom and the second half of the chapter considers recent progress in treatments for drug misuse offenders.

Table 1. The United Kingdom's Legal Classification System

	Drug	Possession:	Dealing
Class A	Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms, amphetamines (if prepared for injection).	Up to seven years in prison or an unlimited fine or both.	Up to life in prison or an unlimited fine or both.
Class B	Amphetamines, Methylphenidate (Ritalin), Pholcodine.	Up to five years in prison or an unlimited fine or both.	Up to 14 years in prison or an unlimited fine or both.
Class C	Cannabis, tranquilisers, some painkillers, Gamma hydroxybutyrate (GHB), Ketamine.	Up to two years in prison or an unlimited fine or both.	Up to 14 years in prison or an unlimited fine or both.

Source: http://www.homeoffice.gov.uk/drugs/drugs-law/Class-a-b-c/

The methods used to define and classify drugs depend upon the need to understand use and abuse. Hence, whilst a biopsychological approach categorises according to psychopharmacological effect, a legal classification categorises on the basis of perceived health and social risk. Julien (2005), largely classifies drugs according to their psychopharmacological effects. Hence, whilst

alcohol, barbiturates, benzodiazepines, and second-generation anxiolytics are defined as *sedative-hypnotic drugs*, cocaine, amphetamine, caffeine and nicotine are collectively referred to as *psychostimulants*. Similarly, other drugs are defined on the basis of their *biological* (e.g. anti-depressants) and *therapeutic* (e.g. Gingko) treatment potential. A final umbrella group of drugs are defined according to their *abuse properties* (e.g. Cannabis). Alternatively, a series of UK legislative procedures has resulted in a legal system that classifies drugs on the basis of their risk to the individual and society. Here drugs are grouped into *Classes A,B, & C* (see Table 1) where guideline penalties are suggested for possession and dealing. Alongside these are other controlled substances such as inhalants, alcohol and tobacco that have age, purpose and location restrictions.

This classification system forms part of a long history of UK legislative acts dating back to the 1860s and passing through distinct phases (Reuter & Stevens, 2007). Reuter and Stevens (2007) note that the first attempt to regulate the access and sale of substances occurred through the Pharmacy Act (1868). This resulted in the restriction of the sale of poisons and dangerous substances to pharmacies. During this period there were very few controls on drug use, both heroin and cocaine were freely available without prescription and were often sold as a panacea. For example, Coca Cola originally contained extracts from the coca plant and was popularised as a health and energy-providing tonic (Maisto, Galizio & Conners, 1995). The second phase, occurring from the 1920s to the 1960s, referred to by Reuter and Stevens (2007) as *Creating a National System*, saw the introduction of a series of acts restricting the sale and use of opium, cocaine, morphine and heroin to dependent users. This phase also resulted in the criminalisation of cannabis possession. The third phase, *Increasing Control*, occurred as a result of both the increase in heroin prescribing by General Practitioners and the introduction and widespread use of cannabis, amphetamine and LSD (Reuter & Stevens, 2007). This was a tightening up and formalisation of the national system with key legislative acts (e.g. The Misuse of Drugs Act, 1971) imposing penalties for the possession and sale of illicit substances. Reuter & Stevens' final phase, *Integrating Criminal Justice and Health*, occurred from the early 1990s onwards. This resulted in both an increase in the powers available to the authorities (e.g. Anti-Social Behaviour Act, 2003) and the establishment of links between the punitive and treatment processes (e.g. The Criminal Justice Act, 1991)

The United Kingdom has the highest number of dependent drug users and one of the highest rates of recreational drug use in Europe (Reuter & Stevens, 2007). A recent British Crime Survey (2006) showed that 34.9% of the 16-59 year old people sampled reported lifetime use of an illicit substance with 13.9% stating that they had tried a Class A drug. Self-reported use in the past year showed that cannabis was the most frequently used drug (8.9%), followed by cocaine (2.4%), ecstasy (1.6%), amphetamine (1.3%), amyl nitrate (1.2%), and hallucinogens (1.1%). When the figures are calculated for people aged between 16-24 self-reported use rates increase to 45.1% with 16.9%

reporting Class A drug use. Observation of past year use shows that 21.4% reported using cannabis, this is followed by cocaine (5.9%), ecstasy (4.3%), amyl nitrate (3.9%), hallucinogens (3.4%), and amphetamines (3.3%); see Roe and Man (2006) for full details on self-reported drugs use in the UK.

Defining drug misuse offending

Drug misuse offending may be defined as any unlawful act associated with drug use. Hence, a person may be labelled a drug misuse offender if they have used an illicit drug, allowed drug use on their premises or have committed an offence whilst intoxicated with either an illicit drug or a legal controlled substance. However, the focus on misuse offending is generally directed to situations where the individual is either selling illicit drugs or is engaging in a drug-taking/acquisitive offending pattern of behaviour. The two drugs (and their derivatives) most commonly associated with these *crime-spree* scenarios are opium (heroin, morphine) and cocaine (crack); this association is linked to the notion that these drugs are the most likely to lead to dependence. A recent estimate suggests that there are 327,000 regular users of these drugs in the United Kingdom, with 281,000 opiate users and 193,000 crack-cocaine users (HMG, 2008). Hammersly, Marsland and Reid's (2003) analysis of young offenders and drug use found that the type of offence most commonly linked to substance use was theft (92% of cohort). This was followed by wilful damage (80%), shoplifting (80%), fighting/disorder (71%), buying stolen goods (70%) and selling stolen goods (70%). The proposed economic cost of drug misuse offending in the UK is £15.4 billion (HMG, 2008). A general estimate of the US costs of all types of substance use in 2002 was $430 billion with $170 billion of that cost linked to alcohol use and $138 billion linked to cigarette smoking (cited in Julien, 2005).

As noted, the popularised link between drugs and offending posits the individual as an addict committing crimes to fund their habit; the *economic necessity* hypothesis. However, recent reviews of research into the link between drugs and crime have challenged this model (Albery, McSweeney, & Hough, 2003; Pudney, 2002; Seddon, 2000). For example, Pudney's (2002) study of the sequence of initiation in to crime and drugs showed that criminal and truanting activities preceded drug taking *per se*, occurring up to four years prior to the age of onset for drugs associated with the economic necessity model; crack cocaine and heroin. Thus, research and review materials tend to proffer a complex interaction between drug taking and other criminal activities that also requires the consideration of tobacco, alcohol, family circumstances, deprivation and schooling. Albery *et al.* (2003) cite five potential links between drugs and crime. These are:

1. The act of taking drugs is a criminal act

2. Drug taking may lead to other forms of crime
3. Non-drug taking crimes may lead to drug taking
4. There is a complex interaction between drug taking and other crimes
5. There are associated causes that lead to both non-drug taking and drug taking crimes

The link is further compounded through the inevitability of a *drug causes crime* scenario, suggesting the likelihood of an eventual causal relationship arising from drug dependence (Bennett & Holloway, 2005). Further, the statistics also indicate that young males are most likely to commit crimes (14-18 years old) at the same age that they are also likely to try drugs. Finally, statistics on the numbers of prisoners who have drug misuse problems further obscure the association. For example, Penfold, Turnbull and Webster's (2005) study of current prisoners and prison staff in six prisons in the UK suggested that heroin, crack cocaine, and cannabis use were prevalent.

However we choose to understand the association between drug misuse and criminal behaviour, interventions and treatments are justified on the basis that: there is clear evidence that drug misusers are likely engage in *crime-spree behaviour*; drug misuse increases the likelihood of offending; and, as a group, drug misusers have higher levels of contact with the criminal justice system (McSweeney, Turnbull & Hough, 2008).

The Development of Intervention and Treatment Programmes

> *"Treatment can be defined in general terms as the provision of one or more structured interventions designed to manage health and other problems as a consequence of drug abuse and to improve or maximize personal social functioning."* (UNDOC, 2003, Chapter II, p.2)

An observation of the history of interventions and treatments for drug misuse shows cycles of tolerance and prohibition (Blume, 2000). The earliest forms of intervention occurred as a response to opium dependence and were largely administered by General Practitioners (GPs). A well known example is the British Model, whereby until the 1960s GPs were free to prescribe heroin and cocaine to those they diagnosed as dependent. The patients then picked up the drugs from their pharmacy. As this practice resulted in a minority of GPs over-prescribing the procedure was stopped in 1967 (The Dangerous Drugs Act) and 1,000s of people were referred to newly established specialist Drug Dependency Units (Farrell, Sheridan, Griffiths & Strang, 1998).

In the 1960s an increase in illicit drug use occurred as the drug culture in the USA became popular in the UK. Consequently, many of the early treatments and interventions were based upon those

that had been developed in the USA. The earliest examples of these were, Christian-based programmes and therapeutic communities. The most accessible and easily transferable model was the *twelve-step* programme (or *Minnesota Method*) that had been adapted from alcoholics anonymous (AA) to narcotics anonymous (NA). These programmes adopted a disease-based model of alcohol and drug dependence with a spiritual method of sustained recovery. The first seven steps (see Figure 1.) focus upon an acknowledgement of the addiction and a desire to withdraw from drug taking. The final five steps resolve to maintain the change in behaviour and rectify the problems they have caused. These steps are the focus of anonymous meeting groups. Therapeutic communities also emerged during this period. The aim of this approach was to provide an asylum for drug users where peers are encouraged to both support each-other in abstinence and confront each-other in doubt. Two similar approaches emerged, first the user-oriented and democratic UK based Maxwell Jones model such as the Phoenix House Project and second the USA based Synanon approach such as the Richmond Fellowship Crescent House Project (Dale-Perera, 1998). Finally, this period also witnessed the development of non-statutory street-based agencies offering informal advice, counselling and information to drug users (Dale-Perera, 1998).

Figure 1. The 12 Steps (Alcoholics Anonymous, 2001)

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His Will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The 1970s and 1980s saw further developments in the treatment of drug users. The Misuse of Drugs Act (1971) established clear penalties for drug users and dealers. Drug workers and Drug teams were established, those who worked with drug users came together to form integrated units and SCODA (Standing Conference on Drug Abuse) was established to bring together non-statutory services (Dale-Perera, 1998). There was also an increase in substitute opiate prescribing for heroin users with a tendency to prescribe oral rather than injecting methadone (Farrell *et al.*, 1998). The most important factor occurring during this period was the emergence of HIV/AIDS in the mid to late 1980s. This threatened to reach epidemic proportions in those who injected drugs and led to a rise in harm reduction procedures. As the threat of HIV/AIDS became bigger than the danger of drug using, outreach projects developed that focused upon helping hard-to-reach users. Similarly, needle-exchange schemes were set up that supplied clean injecting equipment and safe disposal units (Dale-Perera, 1998). Finally, the use of *drug rooms* was piloted in the Netherlands. The policies, interventions and treatments in the 1980s were characterized by a general rhetoric supporting hard-line abstinence policies (e.g. the Raegan's "Just Say No!" campaign) set against local-level implementations of harm reduction procedures designed to avoid the spreading of infectious diseases.

The early 1990s showed a dramatic change in drug policy, harm prevention and reduction merged into an integrated whole and there was a specific emphasis upon developing a consistent policy with measurable outcomes such as the Home Office's Drug Harm Index (DHI). The Criminal Justice Act (1991) refocused the debate with the formal introduction of treatment as a condition of probation. This was followed by the Government's *Tackling Drugs Together* proposal that required the police to introduce drug strategies, and later by the Crime and Disorder Act (1998) which required Drug Treatment and Testing Orders (DTTO). Coupled with these initiatives was the short-lived introduction of a UK Drug Czar (Keith Haliwell), the development of a National Treatment Agency and National and local information (FRANK) and communication (Connections) programmes. These more recent developments emphasise abstinence, treatment and harm reduction in a unified package of services aimed at reducing drug misuse offending.

From the *ad hoc* developments in the 1960s interventions and treatments have proliferated, targets have been set and achieved on the number of people receiving help (HMG, 2008), points of access have been varied to include the hard-to-reach clients and there is a transition from service to service. Prior to providing an overview of the UK's present system of services a brief review of the types of treatment available will be given. Stevens, Hallam, and Trace (2006) provide a thorough overview of the different types of treatment available to problem drug users. These include: low threshold; detoxification; pharmacotherapies; talking therapies; and alternative therapies. The following summary will adopt this classification.

Low threshold services are those that provide simple and efficient ways of reducing problem drug use threats. They include, drop-in services, needle exchange, targeted delivery of health care, outreach services, and drug consumption rooms (Stevens *et al*., 2006). Drop-in services provide basic lifeline assistance such as food, clothing and shelter, as well as advice on employment, health and welfare. These services may act as vital communication points that maintain the contact between the problem drug user and the services provided to assist them back into society. As noted, needle exchange services arose from the fears of HIV/AIDS and more recently Hepatitus B and C. They provide users with the paraphernalia required to avoid these infectious diseases; needles, syringes, spoons, filters, water, citric acid, and condoms. Initial fears that these services would increase drug use proved to be unfounded and considerable research has shown that they play an important role in reducing blood-borne diseases in drug users; see Gibson, Flynn, and Peralec's (2001) meta-review of research.

To provide a targeted healthcare delivery service it is necessary to set up clinics close to areas of high drug use. They may provide professional or peer assistance, shelter, or medical services to *hard-to-reach* groups such as, the homeless, sex workers and other vulnerable groups (Stevens *et al.,* 2006). The most controversial low threshold service is the drug consumption room. Like most of these interventions the rooms emerged in the late 1980s from the need to protect injecting users from infectious diseases. Reviews of the use of safe rooms show that they provide a range of services that reduce needle sharing and assist in the welfare and education of high risk users (Kerr, Tyndall, Li, Montaner & Wood, 2005; and, Kimber, Dolan & Wodak, 2005).

> *"Multiperson use of needles and syringes contributes to a considerable illness burden in both developed and developing countries. Use of nonsterile syringes can occur within the context of illicit drug injection and is associated with transmission of blood-borne pathogens, including HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV), human Tcell lymphotropic viruses, and even malaria. Syringe sharing, or even reuse of syringes by the same person, increases the risk of endocarditis, cellulitis, and abscesses."* (Strathdee & Vlahov, 2001, p.1).

The second category of treatments listed by Stevens *et al.* (2006) are detoxification procedures. The aim of a detoxification programme is to decrease the drug users physical and psychological dependence on a drug. This is a difficult procedure as detoxification leads to a host of withdrawal symptoms (e.g. pain, fever, and craving). Consequently, users are often placed on substitute drugs that are less harmful but mimic some of the effects of the drug (e.g. methadone as a replacement for heroin) or they are given drugs that block the effects of the to-be-withdrawn substance (e.g.

naltrexone decreases the effect of heroin). These procedures are carefully introduced and monitored (the maintenance programme) and are coupled with psychological and social counselling. A successful programme removes dependence whilst limiting the amount of trauma to the individual. In the past two decades ultra-rapid opioid detoxification (UROD) programmes have been developed which combine the antagonist effects of naloxone and naltrexone with the analgesic and sedative effects of anaesthetics. The purpose of these 4-6 hour detoxification procedures is to remove the intolerable effects of dependence as quickly as possible (see Kaye, Gevirtz, Bosscher, Duke, Frost, Richards, & Fields, 2003). UROD is not a magic bullet, and the effects of withdrawal persist but the aim is set them at manageable levels so they can be dealt with on a symptom-to-symptom basis.

In order for detoxification to succeed the drug user must be highly motivated to come off the drug. Unfortunately the level of commitment is too strong for every dependent user to succeed and in these circumstances an alternative pharmacotherapeutic may be adopted. This involves the prescribed replacement of the harmful drug with a less dangerous alternative. Following the withdrawal of L-alpha acetylmethadol (LAAM) in 2004 the main drugs used to substitute opiate dependence are Methadone and Buprenorphine. Controversially, dexamphetamine may be used to treat cocaine dependence, however, due to potentially dangerous side-effects this should be done in conjunction with continued medical examination (Stevens *et al.*, 2006). The importance of pharmacotherapies to both the individual and society is highlighted by Julien's review of the treatment of opiate dependence:

> *"Opioid dependence is a brain-related medical disorder (characterized by predictable signs and symptoms) that can be effectively treated with significant benefits for the patient and for society. However, society must make a commitment to offer effective treatment for opioid dependence to all who need it. Everyone dependent on opioids should have access to methadone, LAAM, or buprenorphine maintenance therapy in a methadone clinic or in a physician's office."* (2005, p. 494).

Reviews of the use of substitute drugs to treat drug misuse offenders have shown that they are affective in reducing both drug misuse and acquisitive offending (Hammersley, Forsyth, Morrison & Davies, 1989).

The fourth category of treatments listed by Stevens *et al.* (2006) are talking therapies. Therapeutic communities (TC) have been an integral feature of drug treatment and intervention for the past 40 years. Many of these drug-free projects that thrived into the 1980s have since faced hard social and economic challenges. The emergence of the HIV/AIDS epidemic reframed the treatment process

toward a harm reduction approach that sat awkwardly beside the abstinence ideology of the TC (Broekaert, 2006). Residential rehabilitation is particularly problematic because it is both an expensive and selective form of treatment. Projects are trapped in an economic-quality cycle with a value system excluding the *hard-to-reach* drug misuse offenders and an environment that has difficulty tackling the psycho-social aspects of dependence. These projects were developed through the belief that substance dependent individuals are capable of removing drugs from their lives. In the first decade of the 21st Century they are adapting to social and economic needs. As Broekaert states in his review of the future of the TC in Europe:

> *"The drug-free TC extended its approach to other target groups, such as prisoners, mothers and children, adolescents, dually diagnosed residents, methadone maintained clients, chronic abusers and mental health patients. TC treatment, methadone programmes and harm reduction methods have been integrated. Brief interventions have been introduced that utilize family and social network support. The TC movement has adopted post-modern approaches that advocate the introduction of shorter programmes, de-institutionalization, outreach and community-based interventions."* (2006, p. 1678)

Many of the contemporary talking therapies are based upon an eclectic mixture of humanistic, behavioural and cognitive approaches. Stevens *et al.* (2006) highlight three types of therapy (motivational interviewing, cognitive behavioural approaches and community reinforcement and contingency contracting) that have all been successfully applied to substance dependent individuals. Motivational interviewing is a non-coercive, goal-directed, client-centred counselling technique aimed at identifying and focusing upon ambivalence. It is normally applied to addictive behaviours but may be used in other circumstances (Rollnick & Miller, 1995). The key to motivational interviewing is to encourage the client to recognise that there is conflict in their lives. It neither aims to diagnose the source of the conflict nor to offer specific advice on how to change the behaviours. In this respect it differs from traditional methods that seek change through confrontation.

Motivational interviewing may be used as an early assessment approach in a structured prevention programme that includes cognitive behavioural therapy (CBT) and community reinforcement and contingency contracting. CBT is a general approach premised by the notion that thoughts, behaviours and emotions are fundamentally entwined in the individual. CBT works in the present to change problematic thoughts and behaviours. Its aim is to provide drug misuse offenders with the skills and strategies to avoid offending behaviours. The effectiveness of CBT is dependent upon the implementation services that assist the opportunity for change. These reinforcements and

contingencies include, family counselling, providing drug-free social networks, improving job opportunities, and implementing positive reward programmes such as token economies (Stevens *et al*., 2006).

Example DIP Success Story: Brian (pseudonym) Male, 37

Intervention: CARAT services in prison; Probation supervision and community treatment; Police monitoring via PPO scheme

Case and Outcome: Brian had a total of 46 previous convictions spanning a 20-year period and was responsible for 125 criminal offences including burglary, theft, fraud, assault, drugs and firearms offences. He served several prison sentences and his last saw him released in July 2007. He had PPO [Prolific and other Priority Offender] status for several years and had caused the local community much harm and distress. Brian had a long history of Class A drugs misuse and had a heroin and crack cocaine addiction for several years. He first tested positive on arrest in July 2004.

DIP measures have been taken since this and the police team have continually enforced treatment conditions when in force and offered treatment through DIP treatment providers at other times. As a result, Brian has not been arrested since July 2007 and has been in drug treatment since his last release from prison. He is prescribed methadone through local drug services and has engaged in the 12-step programme. Brian has not taken illegal drugs in all that time. He is now being removed from the PPO list and his whole attitude to life is being changed. His health is much improved and he has recently completed a sponsored run in aid of charity.

Source: http://drugs.homeoffice.gov.uk/publication-search/dip/dip-success-stories-2008

It is hoped that this section of the chapter has provided the reader with an overview of the context in which substance users offend and the general psychological methods used to enable these individuals to function in society. The remaining section provides an overview of how the UK has integrated treatments and interventions into a single and effective service.

The UK Government's response to drug misusing offenders

> *"Despite some methodological limitations, recent studies seeking to assess the impact of the Drug Interventions Programme (DIP) have reported some successes in terms of*

delivering improved rates of engagement with drug treatment and sustaining high rates of retention." (McSweeney, *et al*., 2008, p.6).

The Drug Interventions Programme (DIP) began in April 2003 as a UK Government (Home Office) initiative to tackle Class A drug misuse and the associated acquisitive crime. During the early development of DIP there was little evidence, either in the UK or the rest of the world, from which to draw a macro level national programme of support and help for drug misuse offenders. Consequently, an indirect evidence-base and policy context was drawn from the following documents: Social Exclusion Unit Reducing Re-offending Report (Fox, 2002), Through The Prison Gates (Morgan & Owers, 2001), Justice For All White Paper (2002) and the Updated Drug Strategy (Home Office, 2002). From these documents, nine areas were identified as key to reducing re-offending and drug taking behaviour. These were: education and training; employment; drugs and alcohol rehabilitation; mental and physical health; attitudes/life skills; housing; debt and benefits; and, family networks.

The aim of the of the DIP was to develop throughcare and aftercare procedures that ensured a continuity of treatment and intervention from the drug misusers', point of arrest, to sentencing, release from prison or community service, and integration back into the community. These procedures focus upon enabling, encouraging and coercing the individual to adopt and cope with a drug-free lifestyle. In order to achieve this the procedures are managed by Criminal Justice Integrated Teams (CJITs) outside of prisons and Counselling, Assessment, Referral, Advice and Throughcare (CARAT) workers inside prisons.

Appropriate individuals are referred (predominantly by Criminal Justice System 'agencies') to CJITs who firstly assess the individual's needs; see example success stories. CJIT workers then help the individual to access the appropriate range of interventions from the previously noted nine areas. CJITs use a multi-agency approach to work closely with those involved in providing the interventions. For example, they may seek support from, jobcentre plus, education services, GPs, local mental health teams, drug treatment services and housing services.

Example DIP Success Story: Danielle (pseudonym) Female, 27

Intervention: Restriction on Bail; Debt and benefit management; Housing support; Tier 3 prescribing; Alcohol intervention; One-to-one Sessions; Crisis intervention; Motivational interviewing; Solution focus therapy; Education, training and employment support.

Case and Outcome: Danielle had been using heroin, crack and alcohol daily for seven years. During that time, there were only two days when she had not used. When she signed up to Kirklees DIP in September 2007, following her arrest, she was testing positive for opiates and cocaine. Danielle was also injecting in her neck and drinking heavily. She attended her Follow Up Assessment and met her case manager, with whom she discussed her needs and the support she required.

Leading up to her court appearance in November 2007, Danielle was engaging with her case worker and regularly attending her appointments. In court she was bailed on condition she engaged with DIP. At that time Danielle owed £7000 in housing benefits and was also in arrears with her gas, water, electric and TV licence but despite these problems she completed her bail without any breaches and made the decision to continue to engage with DIP voluntarily. Her case worker referred Danielle to the DIP housing manager, who managed to get her housing arrears cancelled. Her case worker then dealt with all Danielle's other outstanding bills, getting them 'quashed' and organised for her to start afresh, paying her bills weekly.

To help with Danielle's drinking problem she completed a "drink diary", which involves logging everything you drink daily and then the following week, aiming to reduce on the previous week's intake.

When Danielle told her case worker that she was interested in getting back into computers, she was put in touch with Dewsbury College and attended an open day at the college, where she is now undertaking a computer course. Just three months after her arrest, Danielle was testing negative and continues to do so. She attributes her success to DIP and, of course, her case worker.

Source: http://drugs.homeoffice.gov.uk/publication-search/dip/dip-success-stories-2008

The Drug Interventions Programme also consists of a range of coercive interventions including, drug testing on arrest and charge, required assessment, conditional cautioning, drug rehabilitation requirements and required assessment. Some of these are available across England and Wales and some are only available in specific areas. The idea is that the different elements of DIP together provide an opportunity to offer a drug misusing offender treatment and support at every stage of the criminal justice process. The aim is to draw as many problematic drug misusing offenders as possible, including those on the fringes of offending into treatment and support and to maximise their engagement and retention in that support.

Example DIP Success Story: Martin (pseudonym) Male, 35

Intervention: Throughcare and aftercare support, prison referral *Case and Outcome*: Martin was a prolific offender and had served 15 to 20 prison sentences. He had used illicit drugs since the age of 12. Coming to the end of a prison sentence for burglary, he was assessed and referred to relevant treatment agencies Since completing the 12-step programme, Martin has been in recovery for two years, hasn't re-offended and has gained access through the courts to see his daughter

Source: http://drugs.homeoffice.gov.uk/publication-search/dip/dip-success-stories-2008

DIP also has strong connections with Counselling, assessment, referral, advice and throughcare (CARAT) workers in prisons which provide the link for drug misusing offenders from prison to community based support to further help maximise retention in treatment. Some of the DIP measures offer offenders the choice to take up drug treatment and support in order to avoid a more severe criminal justice penalty. Whilst this may be viewed as a coercive form of drug treatment there is research to support its efficacy (Skodbo, Brown, Deacon, Cooper, Hall, Millar, Smith & Witham, 2007).

Evidence suggests that DIP is having an impact on reducing drug misuse and the associated crime. Since DIP began drug-related crime has reduced by a fifth, furthermore over 1,000 drug misusing offenders have entered treatment, a 'record number'. (www.drugs..gov.uk, 2008). Research that examined the DIP's impact found that drug misusing offenders reduced their offending by 26% after they had been identified and maintained contact with the DIP. Nearly half of the cohort had reductions in offending of 79%, whilst 25% maintained a similar level of offending and 28% showed increased levels of offending (Skodbo, *et al.,* 2007). However, establishing a direct cause and effect was not possible as no control group was used. Further research which evaluated the Aftercare element of DIP showed that a sample of participants on six CJIT caseloads significantly reduced their Class A drug misuse. Furthermore, acquisitive offending reduced by 34% for those who had been on the caseload of for between 11-13 weeks (Love 2007).

Conclusion

The aim of this Chapter is to inform the reader of a range of issues related to treatments and interventions for drug misuse offenders. The increase in drug use in past 50 years has caused considerable disruption to UK society, ruining lives, families and communities. Whilst initial *ad hoc* reactions from legislators had little impact upon the problems, recent coherent and inclusive policies have shown some successes. It is essential that these policies continue to be informed by

researchers in the social sciences. It is also important that the appropriate drug treatment services are available to tackle those substances being abused and causing the most harm to individuals, communities, victims and the families of those affected.

Further exploration of the prevalence of dual diagnosis among offending populations is necessary. The relationship between different types of drug misuse including poly-drug misuse and different types of mental ill health among both community and prison based offenders is required. The efficacy of addressing mental health and dual diagnosis issues in drug treatment programmes also warrants attention.

Whilst outside the scope of this chapter it is equally important to ensure that preventative measures are targeted at the next generation of potential problematic drug misusing offenders. This includes the children of drug misusing parents and the younger siblings of drug misusing offenders, which forward thinking programmes already address.

Dual diagnosis & drug misusing offenders

There is no direct evidence of a link between dual diagnosis and drug misuse offending but there is considerable indirect support for the importance of future investigation. Research has focused upon three key associations: drug misuse and mental health; prisons and mental health; and offending and dual diagnosis. These are discussed below.

Findings in the UK indicate that mental health disorders for those with drug misuse problems are higher than for the general population. (Department of Health 2002). For example, Strathdee et al (2002) found that 93% of clients in drug misuse services indicated mild to moderate mental health problems; depression (41%), generalised anxiety and panic attacks (55%). Weaver et al (2002) found that nearly 75% of clients of drug services had mental health problems; depression and/or anxiety disorder (68%), severe anxiety (19%), mild (40.3%) and severe (26.9%) depression. Finally, Marsden et al (2000) found that 29% of opiate dependant clients in drug treatment services had anxiety and 26% had depression.

The Social Exclusion Unit Reducing Re-offending Report (2002) found that male (x14) and female (x35) prisoners were more likely to have a mental health disorder than the general population. They found that approximately 70% prisoners had two or more mental health disorders and that 40% of male prisoners and 63% of female prisoners had a neurotic disorder. The Institute of Psychiatry (1998) found that 66% of prisoners on remand had a mental health disorder and 39% of sentenced prisoners had mental health disorders. The Mental Health Foundation (1998) found that 55% of prisoners had some form of neurotic disorder and that most prisoners had a high prevalence of depression and general worry. Strathdee et al (2002) study of primary care services found that those with an indication of dual diagnosis were at greater risk of criminal behaviour than those with no dual diagnosis. For example, 62% of patients in forensic services had a dual diagnosis. Research also shows that those with dual diagnosis were at greater risk of offending behaviour (Banerjee et al., 2002; Tessler & Dennis, 1989).

Combined this research shows the importance of understanding the link between drug misuse, mental health, and offending. Especially as those with a dual diagnosis have problems accessing help for either their drug or mental health problem or both (Department of Health 2002, Mind 2007, Social Exclusion Unit 2002, Banerjee et al 2002). The Department of Health (2002) suggests this is because mental health and drug treatment services have developed separately and consequently there are few services that deal with both problems concurrently. Wanigaratne et al (2005) suggest that addressing a drug misuser's mental health can have beneficial effects on their drug taking behaviour. They also claim that the psychological health of clients on any drug treatment

programme should be a key outcome measure of the efficacy of that programme (see also, Wilke, 2004; and, Bean & Nemitz, 2004).

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